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1949

Supreme Commander for Allied Powers.  
Public Health and Welfare Section.  
Mission and Accomplishments of  
Occupation in Public Health and Welfare  
Fields

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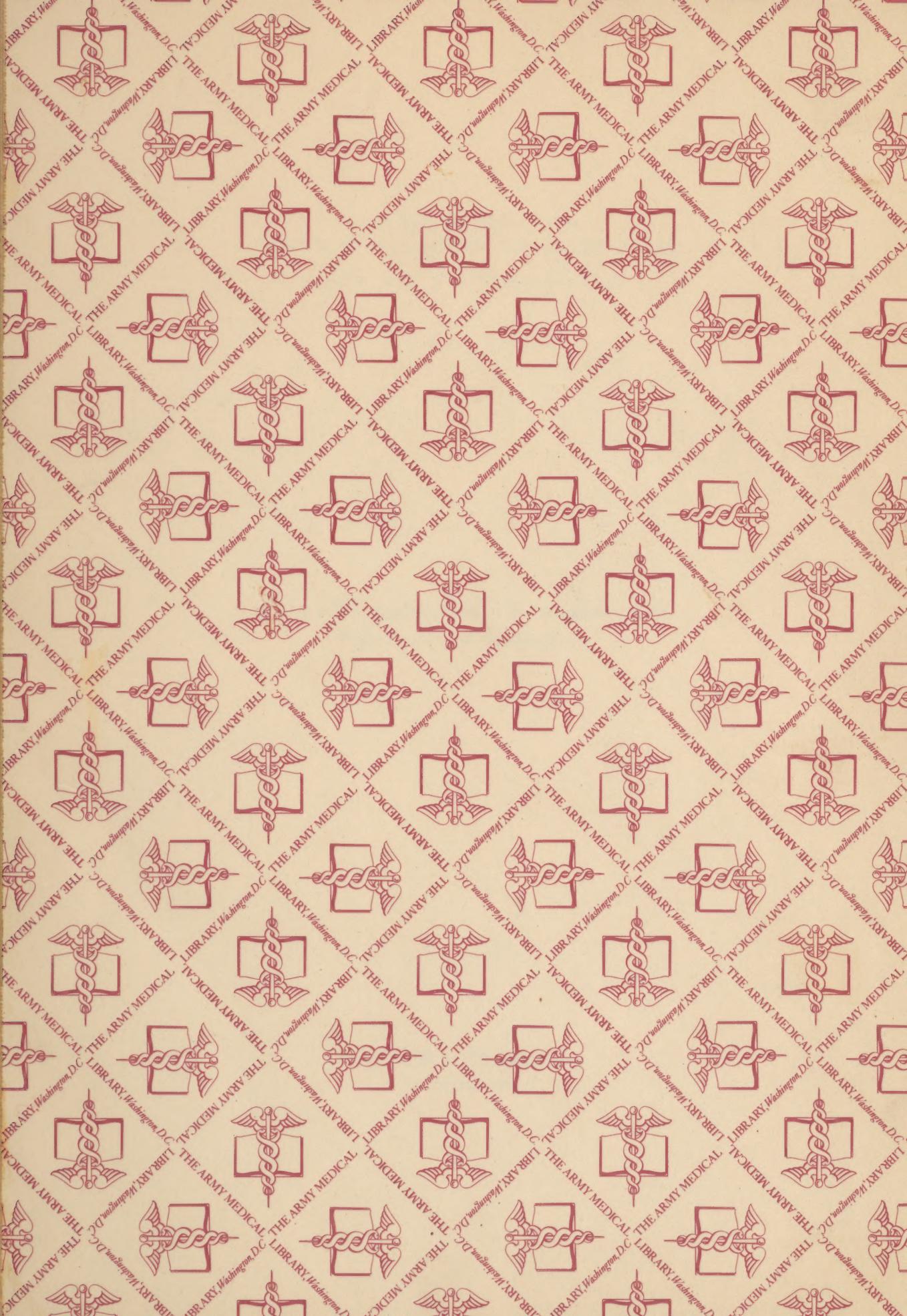


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Health and Welfare Section

Mission and Accomplishments of the Occupation in the  
Public Health and Welfare Fields



Public Health and Welfare Section  
December 1949

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MISSION AND ACCOMPLISHMENTS OF THE OCCUPATION  
IN THE PUBLIC HEALTH AND WELFARE FIELDS

The primary mission of public health and welfare programs as carried out by SCAP in Japan is to prevent widespread disease and unrest. In reviewing SCAP programs in the inter-related fields of health and welfare, it is desirable to briefly describe the health and welfare organization in Japan and the situation as it existed at the beginning of the Occupation on the 30th of August 1945.

I. ORGANIZATION

1. Prior to the termination of the war such health and welfare activities as existed in Japan were primitive in nature and ineffective in practice. A Ministry of Health and Welfare was established in 1938. This Ministry included the functions of Health, Social Affairs, Social Insurance and Labor. Within the prefectoral or state organizations, health sections were in most instances under police control. On the local level, such health and sanitation activities as existed were carried out by the police and the neighborhood associations, which controlled all phases of Japanese life. Health centers had been established in 1922. However, they were primarily advisory clinics for tuberculosis or mother and child hygiene activities and had neither the organization, staff or authority to carry out public health functions as considered essential in modern public health practices.

2. It was obvious that in order to carry out health and welfare programs to prevent disease and unrest, a sound organization from the national to the local level would have to be established. This organization would of necessity have to conform to the general reorganization of the Japanese Government in accordance with the new constitution adopted by the Japanese after the termination of the war.

a. The Ministry of Welfare was reorganized to integrate the four fundamental aspects of health and welfare; that is, the preventive medicine aspects, the medical care aspects, the welfare aspects and the social security aspects of this problem. Labor activities were removed from the Ministry of Welfare and incorporated in a new Ministry of Labor. The Ministry of Welfare under the new constitution is the agency of the executive arm of the Government responsible for administration of laws passed by the Diet pertaining to health and welfare. It must be understood that in Japan a federal form of government like that in the United States does not exist. The Government is national in form and residual power rests in the national legislature or Diet, rather than in the States. The prefectures or states do not have constitutions. The state or local assemblies may pass legislation only as authorized by the National Diet. Therefore, health and welfare

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legislation in Japan is national in character, rather than state or local in character, as in the United States.

b. Health Departments and Welfare Departments have been established in 1946 and 1947 in all prefectural governments on a co-equal status with all other major departments of prefecture governments. These departments are charged with administration of the national laws on the prefectural level.

c. Health Center Districts, founded on the basis of one (1) per 100,000 population, headed by district health officers under the supervision of the prefecture health department chief, have been established for the administration of health laws on the local level. These health center districts contain at least one completely organized and staffed health center and as many branches as the distribution of the population within the district may require. In the field of welfare, corresponding welfare districts are established for administration of the welfare programs.

## II. PREVENTIVE MEDICINE

1. Communicable Disease Control: a. Japanese standards of sanitation and public health practices were, in most instances, far below those of the more progressive nations. Public water and sewage systems, which existed only in the larger cities, had been severely damaged as the result of bombings. Those that escaped war damage were in need of considerable repair. The vaccination program against smallpox had been discontinued. Environmental sanitation was virtually nonexistent, presenting a definite threat of epidemics of dysentery, typhoid, or typhus.

### (1) Smallpox

- (a) The incidence of smallpox had been steadily increasing since 1938, and the need for prompt and vigorous control measures was recognized. However, vaccine was not immediately available and there were many problems that had to be solved before adequate quantities of standardized vaccine could be manufactured. An epidemic developed rapidly and reached its peak in March 1946.
- (b) Immunizations succeeded in bringing the epidemic under control during the spring and early summer of 1946 but not until more than 17,000 cases had occurred among the indigenous population. The mass immunization of the entire population together with the routine vaccination

and re-vaccination of all infants and school children, as required by the Preventive Vaccination Law No. 68 of 1948, has eliminated smallpox as a major public health problem. During 1949 there was a total of only 124 cases in Japan. A re-vaccination of the entire population was again undertaken in 1949 to reinforce the immunity lost since the previous vaccination of 1946. (See Chart No. 1)

(2) Typhus

- (a) Typhus fever has been endemic in Japan for many years. Most of the cases in 1945 centered in Hokkaido which the Japanese claim had been imported by Korean slave laborers.
- (b) Following the confirmation of the presence of typhus in Hokkaido in October 1945, control measures were promptly initiated in an effort to prevent an epidemic. An attempt was made to halt the spread of typhus into Honshu but this action came too late, since Korean miners from Hokkaido, who were endeavoring to return to Korea between 16 August and the arrival of the Occupation Forces, had already spread the disease throughout Japan. The disease in December 1945 reached epidemic proportions. Typhus vaccine, DDT, and other essential supplies were not available from indigenous sources and had to be imported from the United States. Control measures were vigorously pursued and the epidemic abruptly halted. The peak was reached in March 1946 instead of May, the peak month in previous years. A total of 31,141 cases were reported in 1946. With the exception of a few small local outbreaks in the Osaka and Tokyo areas, there has been a gradual decline in incidence during the following three years - 1947, 1141 cases; 1948, 474 cases; and in 1949 only 121 cases occurred. Case finding teams, vaccinating teams and DDT dusting teams played a very important part in the typhus control program. Approximately 50,000,000 people have been dusted with DDT and 12,892,000 vaccinated in this four year period. Education of the public through the media of the radio, press, pamphlets and posters has been promoted with great success. This information program is continuous. Although typhus control

supplies used initially were imported from the United States, the Japanese were instructed in the preparation and manufacture of these supplies and are now in a position to produce sufficient quantities to meet future requirements without the necessity of further imports.

(3) Diphtheria

- (a) Diphtheria has been extremely prevalent in Japan. Since 1937 when approximately 28,000 cases were reported, the rate had increased each year. In 1944 the number of cases reported was approximately 94,000. The Japanese had never used toxoid for prophylactic immunization. For the seven years preceding 1946 there had always been a peak case and death rate during the months of November and December.
- (b) The necessity for a nation-wide immunization program for children was immediately recognized, but because of non-availability of toxoid and the inability to produce or procure it, it was impossible to conduct the necessary immunization of children during the winter of 1945-1946. Japanese pharmaceutical manufacturers were provided with instructions and the techniques for production. However, even though large numbers of children were successfully immunized and the diphtheria rate decreased remarkably, production and assay techniques were not sufficiently well safeguarded and it was necessary in 1949 to halt production and establish new standards for pharmaceutical manufacture and governmental assay procedures. Routine immunizations as now required under the Preventive Vaccination Law were resumed in the fall of 1949.
- (c) The diphtheria rate has been reduced 86% since the beginning of the Occupation.

(4) Cholera

- (a) No cholera was reported at the beginning of the Occupation. In the spring of 1946, when the repatriation program was well under way, cholera appeared on repatriation ships from China and other Far Eastern countries.

(b) Stringent quarantine control measures had previously been initiated and proved to be very effective in preventing cholera entering Japan through the repatriation program. In April 1946 two cases of cholera were reported from the southern island of Kyushu, then isolated outbreaks began to occur which were subsequently traced to illicit smuggling of Koreans, desiring to return to Japan from Korea, where an epidemic was in progress. Cases continued to increase, totalling 1,229 for the year 1946, most of which occurred during the months of July and August. Stringent control measures consisting of isolation, quarantine, disinfection and focal immunizations were carried out in all areas where cholera appeared. These measures were initiated promptly and proved very effective in preventing a large scale epidemic. As large areas of the population were immunized wherever cases occurred, particularly seaport cities, approximately 34,500,000 persons received cholera immunizations. The last case occurred in December 1946.

(5) Dysentery

(a) Dysentery has always been prevalent in Japan. This is a filth disease which cannot be eliminated or even satisfactorily controlled until the standards of living, unsanitary customs and practices are improved. Medical science has not as yet provided a satisfactory immunizing vaccine capable of controlling this group of diseases. Control therefore lies chiefly in the education of the people in the matter of sanitation, personal hygiene, improvement of water supplies, waste disposal and the control of flies. The dysentery incidence has always been extremely high in Japan with marked seasonal fluctuations during the year. The peak is reached during the months of August and September. The poor economic status of the people, plus the complete lack of sanitation as a result of the war and immediate post-war period, resulted in an actual increased incidence of this disease.

(b) Educational campaigns through the press, radio, posters, schools, and social organizations have

been fostered. Sulfanilamides were made available to physicians in addition to the production of material and supplies for sanitation programs. Training programs for Japanese public health personnel were started. Sanitary teams were organized in 1946 and increased in 1947 to control insects and rodents and promote better environmental sanitation conditions.

- (c) Since exposure to dysentery does not confer lasting immunity, and no vaccines are available, the entire population is constantly susceptible to infection. Since the beginning of the Occupation, there has been a 79% reduction in the amount of dysentery. Continued emphasis to effect dysentery control is placed on the work of sanitary teams and on the activities of sanitary and food inspectors as well as the education of the general public.

(6) Typhoid and paratyphoid

- (a) Typhoid, like dysentery, is a filth disease and has always been prevalent in Japan. During the past seven years the highest reported incidence occurred during the latter part of 1945, due principally to the destruction and disruption of normal sanitary facilities during the latter part of the war. There were reported approximately 58,000 cases of typhoid and 10,000 cases of paratyphoid fever during 1945.
- (b) Prompt action was taken to improve water supplies and waste disposal methods, to control insects and rodents, and to establish an immunization program. Since there is an effective vaccine for typhoid and paratyphoid fever, it was expected that the incidence of these two diseases would be reduced by its use. Minimum standards for vaccine production and assay were established and new cultures were supplied to the manufacturers to insure high potency of their product. The immunization program launched in September 1947, was continued except for temporary suspension during early 1949 to permit review of standards and assay procedures. The Preventive Vaccination Law of 1948 requires initial immunization of all children between 3 and 4 years of age, and annual re-immunization

to the age of 60 years. As a result of both improved sanitation and extensive immunization, the amount of typhoid has been reduced by 90% since the beginning of the Occupation.

(7) Japanese B Encephalitis

- (a) Japanese B Encephalitis has been present in Japan for many years with occasional epidemics having been reported. The last two major outbreaks occurred in 1924 and 1935. The disease, transmitted by mosquitoes, was made reportable in June 1946.
- (b) An outbreak of Japanese B Encephalitis occurred in August 1948, due to incompleteness in the mosquito control program which had been hampered by difficulties in obtaining funds for operation during the spring and early summer months. A total of 7,208 cases occurred in 1948, with an additional 1,284 cases during the summer months of 1949. Whereas endemic cases are reported in small numbers each year from the Inland Sea area of Japan, the 1948 epidemic centered in Tokyo and extended outward to include most of the northern and central Japan. Immunity acquired because of this epidemic is expected to aid in preventing further epidemics for some years.

(8) Tuberculosis

- (a) Tuberculosis has always been extremely prevalent in Japan. Studies on tuberculosis have in the past in all areas relied on mortality statistics in order to obtain comparative results. Since 1932 there had been a steady increase in deaths from tuberculosis and in 1945 had reached a high level accounting for 12-15% of deaths from all causes, with a death rate one of the highest in the world. In the past it was considered a shameful disease, to be concealed whenever possible and very few patients were brought to the attention of medical authorities. The serious economic conditions, lack of food, fuel and clothing, over-crowding and unsanitary conditions during the last years of the war contributed materially to the continued prevalence of this disease. Tuberculosis sanatoria were found in 1945 to be only 25% occupied, mainly due to

active cases leaving these institutions to seek food. These cases were then acting as sources of additional infections. Japanese had been conducting research on BCG since 1927. In 1943 the National Research Council had evaluated the progress made up to that time and concluded that the use of BCG (Tuberculosis Vaccine) vaccine should be encouraged as a means of tuberculosis control. In 1944, 5,025,794 individuals between the ages of 10 and 19 years had been immunized with BCG provided they were negative to tuberculin tests. In 1945, 3,098,444 individuals between the ages of 15 and 24 years were inoculated. BCG vaccine used was of questionable potency in many cases due to lack of standardized assay procedures.

(b) During the first years of the Occupation, the urgency of establishing health control measures for the more acute communicable diseases, such as typhus, resulted in tuberculosis control receiving secondary attention. It was not until October 1946 that an active control program was inaugurated in which the immediate objectives may be summarized under five headings:

1. To encourage the return of active cases of pulmonary tuberculosis to hospitals by providing necessary food supplies and enabling hospitals to care for these patients.
2. Emphasis upon education of the medical and nursing professions in diagnosis, treatment and care.
3. The inauguration of a school lunch program for supplemental feeding of school children to provide a more balanced diet and increased resistance to infection.
4. The mass examination of school children, together with individual case finding, tuberculin testing and BCG immunizations.
5. Mass examination of workers, in factories and other industrial organizations.

(c) Full publicity was given this program through all media of information, radio, press, posters and lay and professional journals and magazines.

Many prefectures organized Tuberculosis Care Committees whose primary function is to assist patients in entering sanatoria, maintenance of their families during hospitalization and obtaining suitable occupations upon their return from the sanatoria. Significant results were immediately noticeable. Through increased rations to hospitals and institutions, augmented by voluntary contributions through LARA (Licensed Agency for Relief in Asia) the food situation has improved and all prefectures are receiving increased diets for tuberculosis patients. A school lunch program was successfully inaugurated and has been expanded to now serve approximately 7,104,881 children. X-ray equipment was furnished by rebuilding old units, also by manufacturing new equipment. Sufficient X-ray film was produced to meet requirements. Case reporting was required in January 1947 and represents the first time that clinical tuberculosis has ever been reported in Japan. The nation-wide examination program for the detection and control of tuberculosis has been vigorously followed. Mass examinations have taken place in factories and schools. The vaccination program was encouraged and approximately 35,000,000 BCG immunizations have been given to date. The control program has resulted in a 40% reduction in deaths since 1945. Study of the deaths by age groups indicates that the entire reduction has occurred in the age groups immunized with BCG. The death rate in non-immunized age groups has not been reduced during this period. The overall reduction in deaths represents both immunized and non-immunized age groups, covering the total population of Japan. Within the immunized groups alone the number of cases has been reduced by 79% and number of deaths by 88%. (See Chart No. 2)

(9) Venereal Disease

(a) Preliminary studies and observations of the venereal disease problem at the beginning of the Occupation revealed that venereal diseases were considered as diseases of prostitutes, primarily, and for this reason were never a cause for concern by either the Japanese physician or the general population. Japanese

physicians, with very few exceptions, were unfamiliar with the epidemiologic and clinical manifestations of venereal diseases. Control methods were almost entirely devoted to the periodic examination of prostitutes and such examinations as were made were perfunctory and practically worthless. No provisions existed for the care of infected persons in the general population. Such clinical procedures as were in effect were archaic; laboratory procedures were poor and inadequate. Contact tracing was not done. Venereal diseases were not reportable and consequently no statistics were available as to the incidence of the venereal diseases. Licensed prostitution was legal and flourished both in brothels and on the streets, so that the opportunity for the spread of venereal diseases was practically unlimited. Segregation of prostitutes into prostitute districts, which was said to be strict before the war, had broken down during the war years. Permits to work as prostitutes were formerly under police supervision but this also became lax during the war.

(b) Faced with the realization that venereal diseases posed a serious problem, on 16 October 1945, syphilis, gonorrhea and chancroid were designated as infectious diseases. Reporting of the occurrence of these diseases and their treatment was required. Instruction, dated 21 January 1946, directed the Japanese Government to abrogate and annul all laws, ordinances and other enactments which directly or indirectly authorize or permit the existence of licensed prostitution in Japan and to nullify all contracts and agreements which have for their object the binding or committing directly or indirectly, of any woman into the practice of prostitution. Reporting started in December 1945, and though the system was new to Japanese personnel the number of cases reported gradually increased each month as physicians became familiar with venereal disease and the machinery for diagnosis and reporting was improved. Under this system, over one and a half million cases of venereal disease have been reported and brought under treatment. Continuous efforts have been made to improve professional techniques, to provide improved hospital and clinic facilities for

venereal disease patients, and to educate both the medical profession and the general population in the medical aspects of these diseases. Treatment facilities for the general population have been established, treatment schedules have been furnished, and clinical and epidemiologic procedures have been demonstrated. Effective drugs such as the sulfonamides, mepharsen, bismuth subsalicylate and penicillin are being produced from indigenous sources. With the exception of sulfonamides, none of these were produced in Japan prior to the Occupation. Besides the clinics operated in the approximately eight hundred health centers, there are other public and private clinics. Regular reports are received from 1705 venereal disease clinics. There are sixty government supported hospitals operated exclusively for the treatment of venereal diseases. A Venereal Disease Prevention Law, No. 167 of 1948, provides for pre-marital examination for venereal disease, a pre-natal examination for venereal disease and examination of all contacts and suspects.

(10) Sanitation

(a) Sanitation in Japan has been in accordance with local standards of living, fluctuating with economic conditions, improving with modernization but generally ignored by the people during their daily activities. Prior to the war and before the Occupation, control of environmental sanitation was accomplished through sanitary associations, and by small local groups of home owners who carried out orders of police officials and political leaders. The conditions resulting from the war, when 50% of the housing facilities of the major cities were destroyed, were added to the public neglect of sanitation standards. Homes, public institutions, railroad stations, tunnels and improvised shelters, many of which had no sanitary facilities whatsoever, were overcrowded. Recognizing the immediate need of improving general sanitary conditions, efforts were first directed to the cleaning and removal of debris resulting from the war, the repairing of damaged water supply systems, and to generally improving environmental sanitation.

(b) Insect and rodent control as a community endeavor was not known in Japan except as it affected agricultural pursuits. In the fall of 1945, sanitary teams were organized and used for the control of typhus, an epidemic disease then threatening the population. Under SCAP supervision, the training of these teams was extended during the spring of 1946 to include insect and rodent control and general environmental sanitation. In 1949 the sanitary teams were on a basis of one team per 13,000 population in areas of 13,000 and above, while one environmental sanitary inspector under supervision of established health centers was stationed in areas of less than 13,000 population to deal directly with public sanitation problems.

(c) Japan has an exceedingly large rat population so that continual efforts are required to eliminate this rodent through the use of poison baits and traps. For centuries the Japanese people have believed that harboring rats in their homes was a good omen and it has taken consistent efforts to prove that the rat is hazardous to human health.

(d) Ample stocks of insecticide supplies and equipment are now on hand to meet all requirements.

(e) It is estimated that only 25% of the Japanese people are served by municipal water treatment plants and distribution systems. Water supply systems have been repaired and expanded as fast as limited materials and the shortage of funds have made it possible. Provisions have been made for adequate amounts of chlorine and chlorine equipment necessary to protect all water supplies. The remaining 75% of the population obtain their drinking water from shallow wells, streams or springs which, for the most part, are liable to dangerous pollution. Specifications of standard well construction, periodic laboratory tests and protection measures have been disseminated thru educational meetings, demonstrations and model construction.

(f) The greatest single environmental sanitation problem involves the utilization of night soil

(human wastes) as fertilizer. The night soil is either collected by farmers who use it for fertilizer, or by contractors who collect and transport it to the country where it is sold to farmers, or by individuals using the material in their gardens. The dry pail method of collection, and disposal by using as fertilizer is the system universally employed throughout Japan. However, in larger cities, construction improvements, adequate storage facilities, public education, research experiments and development of chemical fertilizers has resulted in some improvement of the night soil problem. Only six cities have sewage treatment plants while those cities with collection laterals have an average of 20% of their areas covered for sewage removal. Long range plans have been made for expansion, extension, modernization and yearly maintenance in practically all urban areas.

- (g) All ditches, drains, gutters and streets are poor due to their type of construction and lack of repair. These are gradually being replaced by modern designs and construction. Garbage and refuse removal, although primarily an individual cart system, is improving. New housing construction in destroyed areas has reduced crowded conditions.
- (h) The lack of qualified sanitary personnel was recognized at the beginning of the Occupation. Training schools and in-service training has been instituted throughout the nation. The general public, the supervisors, and workers were instructed on modern sanitary practices adaptable to Japan on problems of water, sewage, insects, rodents, food, garbage, refuse, housing, and disease relationships. This program has been aided through the reorganization of the Institute of Public Health in Tokyo in 1947 and by sanitarian and sanitary engineer graduates of three-month courses.

#### (11) Port Quarantine

- (a) Prior to the war, the Japanese quarantine system was operated by prefectural and local governments under the direction of the Home Ministry and as

prescribed by a national Port Quarantine Law. Since operations were by local governments, the enforcement of regulations varied greatly. During the confusion of war, barriers that had existed against quarantinable diseases broke down completely with deterioration of both personnel and equipment of stations due to their transfer or utilization in the war effort.

(b) The first step to re-establish the quarantine stations was taken with the publication of port quarantine regulations in September 1945, and while stringent compared to the requirements of a modern nation, the high communicable disease incidence in Japan and other nations in the Asiatic areas made it necessary for strict measures to be adopted. Eight ports were then selected for quarantine stations, a full complement of personnel was assembled and trained, in addition to procuring medical and laboratory equipment and supplies from confiscated Japanese Army-Navy stocks and surplus US Army stocks. This was a high priority undertaking but a national coordinated quarantine service was formed and placed under the control of the Ministry of Welfare in time to handle all the medical processing of repatriates which began arriving in the fall of 1945. During this repatriation period quarantine measures were effectively administered in the greatest mass movement of peoples ever to pass through quarantine. Approximately 6,240,000 persons were repatriated to Japan and 1,190,000 persons from Japan in this program, with about 377,000 persons remaining to be repatriated to Japan, principally from Soviet occupied areas.

(c) With the resumption of trade with other countries, an increasing amount of commercial traffic has passed through quarantine. Additional ports of entry have been opened so that at present quarantine services are provided at 13 marine and 2 aerial ports. Standby service for repatriates is maintained at two additional marine ports not officially designated as ports of entry for commercial vessels.

(12) The Institute of Public Health

(a) Prior to 1930 Japan did not possess an institute

whose primary function was the teaching of public health. The Rockefeller Foundation became interested in the public health problem in Japan and subsequent negotiations between the Foundation and the Japanese Government resulted in the establishment of the Institute of Public Health which was completed in 1938. The Institute of Public Health, however, did very little teaching of public health and confined their activities largely to the research field. In 1943 the Ministry of Welfare occupied the building and remained there throughout the war.

- (b) There was a great need in Japan for doctors educated in public health. The only qualified public health officials were the few who had been educated abroad, principally in the United States, England and Germany. Early in 1946 a program was developed to re-establish the Institute as an institution for teaching public health. The first courses for public health personnel began in 1947.
- (c) In the three years since this training program was adopted, 58 courses lasting from 2 to 4 months have been conducted for various categories of public health personnel. A total of 2,408 students have attended. This number includes 400 medical health officers, 437 public health nurses, 454 sanitarians, 390 veterinarians, 276 nutritionists, 127 sanitary engineers and 324 pharmacists and laboratory workers. In addition, 14 special short courses lasting from one to two weeks have been held for personnel from model health centers with a total of 730 persons attending.

(13) Public Health and Welfare Information and Education

- (a) In the fall of 1947 a nation-wide public health information program was initiated and was concerned with the dissemination of pertinent subject material directed or "beamed" to the public through the use of all possible media of transmission.
- (b) In April 1948 an Information Unit was established within the Ministry of Welfare to initiate

information programs and to coordinate these programs with all agencies concerned, both governmental and non-governmental. A quarterly information plan serves as a basic guide in the planning of information programs at all levels of administration.

- (c) Subject material is released over 13 radio programs originating at the national level, one of which, a daily 15 minute program, is devoted exclusively to health and welfare. The six large newspapers released 3,360 articles during 1949 not including releases by local papers. Motion pictures and other visual aids have contributed to the success of the program.
- (a) The education program is concerned with the school health program, the adult education program, health and welfare education for special lay groups and with refresher courses for professional groups. These programs are conducted through organized courses of instruction over varying periods of time.
- (e) With the development of the new health center system to its present state and the establishment of the school boards of education in Japan, the Ministries of Welfare and Education prepared an amendment to the Board of Education Law which will allow for close cooperation between health centers, and the school boards in planning and executing the school health program. This amendment has been presented to the Diet of the Japanese Government.

### III. HEALTH AND WELFARE STATISTICS

1. The collection of vital statistics which had practically ceased in 1945 was resumed in 1946. National, uniform, standard registration forms were prepared and placed in use. In 1949, all registration and transcript forms for births, deaths, stillbirths, marriages and divorces were revised for use during the decennial period 1950-1959. The percent completeness of registrations has reached a high level through the systematic matching of family registrations and reports of attending physicians and midwives. Coverage of reportable diseases has been increased from 10 to 35. A national monthly morbidity transcription system, based on local epidemiological case records was introduced at the beginning of 1949. Hospital statistics have been expanded.

Weekly, monthly and annual publications of health statistics are prepared and sent to prefectural health departments and health centers. Quarterly nutrition surveys which have been conducted since 1945 are based on statistical sampling techniques. Health statistics offices have been established in the Ministry of Welfare, all prefectural health departments and local health centers. Beginning in 1948, transcripts of vital statistics data from original registrations have been routed through health centers and prefectural health departments for their use in health administration.

2. The fifth revision of the International List of Causes of Death in Japan, which was delayed because of the war, was made in 1947 and the sixth revision (1948) was prepared in 1949. National technical advisory committees on health statistics and also on the registration of vital events, which were established in 1946, have been of invaluable assistance in the development of health statistics.

3. Starting in 1947, a series of medical care surveys continues to be conducted. National and regional training programs have been maintained for persons engaged in vital and health statistics at the national, prefectural and local health center levels each year since 1946. Manuals have been prepared concerning health statistics and registration procedures. Plans have been prepared to train physicians in filling out medical certifications. Their quality has been improved and efforts will be made to improve them further. Responsibility for all statistics in the Ministry of Welfare, including welfare as well as health, was given to the Health and Welfare Statistics Division of the Welfare Ministry in June 1949.

#### IV. MEDICAL CARE

1. Medical Education: a. Japan possessed an adequate number of doctors, however, many were graduates of secondary medical technical schools and consequently their knowledge of medicine and ability to practice was limited. All schools had operated under the didactic German system for years, with little emphasis on laboratory or clinical teaching. Progressive advancement was further hampered because qualified instructors were reluctant to participate in medical school teaching, preferring to confine their activities to selected groups of protégés training for the higher degree of Doctor of Science in Medicine leading to a career in research. A certificate of graduation from a medical school permitted the legal practice of medicine and automatic issuance of a medical license. No examination was required.

b. Japan lacked an agency through which reorganization of the medical education system could be initiated. The Japanese Medical Association evidenced no great interest; therefore, it was necessary to recruit a group of Japanese doctors known to possess progressive ideas and representative of the leading medical colleges of the nation.

c. The Council on Medical Education was formed in March 1946 and its recommendations have resulted in establishment of a sound medical education system in Japan. This system is now going through a transitional period which will be completed in 1951, at which time graduates in medicine will have completed two years pre-medical training and four years of medical university training, followed by one year of internship. With the passage of the Medical Practitioners Law in 1948, all graduates are required to qualify for licensure by participating in the National Medical License Examination, the Ministry of Welfare issuing a license to practice medicine upon its successful completion.

2. The Japan Medical Association: a. The Japan Medical Association was a governmental body in which membership was compulsory, with the society dedicated to the control of medical practice and the upholding of national policy.

b. Reorganizing the Japan Medical Association along democratic lines, with removal of all governmental influence, subsequently resulted in the adoption of a new constitution on 31 August 1947. On 9 March 1948 the first national election was held. The new society is dedicated to promote medical ethics, to improve and propagate medical knowledge and techniques, and to advance public health as a means of improving the social welfare. Voluntary membership for those individuals who meet the professional and ethical standards required is now being sought by medical scientists, as well as by the general practitioners. Previously, medical educators and researchers were rarely active in the association which is now regarded as a representative body of all physicians in Japan, regardless of their spheres of activity. Prefectural and local associations have been formed under constitutions patterned after the national organization.

3. Hospitals, Leprosaria and Sanatoria: a. Concentration of the nation's efforts in meeting military requirements during World War II similarly had its effect in the physical deterioration of hospitals and other medical institutions. Large quantities of heating and central cooking equipment had been removed for scrap metal. Military medical installations held large quantities of drugs and medical supplies which were urgently needed for treatment of the civil population. Many hospitals had been without X-ray film for at least three years, were unable to procure adequate amounts of medicine, and also found it necessary to wash and re-use dressings. All Japanese hospitals were "closed" institutions with a paid staff of doctors. Most Japanese civilians received medical care by going to hospitals rather than the doctor's office, as is common in the United States. Therefore, all hospitals had large out-patient services from which in-patients were obtained for the hospitals. The private practitioner who, under the law, had no connection with a hospital staff found it necessary to provide some measure in which he

could retain the care of his patient. As the result, thousands of so-called hospitals of ten beds or less were established by private practitioners to hospitalize their own patients. Surveys determined that physical facilities for hospitals and other medical institutions of more than ten beds, although suffering heavy damage, existed in sufficient numbers to provide adequate hospital beds for the needs of the civilian population. The poor medical service being rendered, plus the fact that hospitals could not provide ample food for their patients, resulted in a small percentage of the available beds being occupied.

b. Early in the Occupation a weekly reporting system on hospitals, by prefecture, was established which included the number of beds available, beds occupied, and number of out-patients treated, in order that the most efficient use could be made of existing beds. There were in 1949, 3,019 hospitals of more than 20-bed capacity in operation in Japan, with a total bed capacity of 249,042. This provided one bed for approximately each 328 persons. During 1949, the number of occupied beds averaged 158,470. An average of 301,707 persons received out-patient treatment weekly during 1949. (See Chart No. 3)

c. In July 1948 the Diet passed the Medical Service Law which provides a legal basis for minimum hospital standards. Under this law, the small, less than 10-bed hospitals may continue to exist as clinics where minor surgical cases or simple diseases may be treated, but no patients may be confined more than 48 hours unless an emergency exists. The law further stipulates that a minimum of twenty beds must be available to obtain classification as a hospital and sets forth hospital standards. In addition, the law establishes a system of inspection and gradation of hospitals, based upon management, personnel, building and equipment, and provides for Governmental grants-in-aid to public institutions for purposes of construction and repair. In connection with these grants-in-aid, a hospital architectural advisory service is maintained by the Ministry of Welfare.

4. Hospital Administration: a. Changes in the operation of Japanese hospitals, to bring the standards of treatment up to modern levels, are under way. Such changes are so interwoven with the medical education program, the nursing education program, the availability of qualified physicians, medical investigators, plus hospital administrators, that improvement in hospital administration will not take place rapidly. Considerable progress has been made in providing better nursing care for patients, establishing central kitchens, securing increased rations, as well as improving general sanitary conditions. The age-old Japanese custom of permitting relatives to live in the same room with the hospital patient, preparing meals and providing care, is being eliminated by establishing central kitchens and regular visiting hours.

b. The lack of competent hospital administrators in Japan is another contributing factor to poor medical care. A committee under SCAP guidance was established to study this problem and provide for faculty, curriculum and teaching facilities. A model hospital has been established in Tokyo and facilities are provided within this hospital for the practical training of administrators. During 1949 this school graduated 299 persons, mostly directors and business managers of hospitals drawn from all sections of Japan. Two courses of two-month duration are given each year and courses of one-week duration are given six times a year. In these courses, public as well as private hospital directors are trained.

5. Dental Affairs: Dental schools in Japan had never attained university level prior to the war. These schools are now established on the same educational level as the medical schools, and six university level dental schools are now in operation and receiving students. With the passage of the Dental Practitioners Law and the Dental Hygienists Law, similar reforms have been established in the field of dentistry described above in reference to medical care. The Japan Dental Association has been reorganized with the idea in mind of becoming a representative body, which would be able to serve the interests of the dentists and advise the national government in regard to dental education and dental care programs.

#### V. NURSING AFFAIRS

1. Nursing in Japan was looked down upon as being in the category of the servant class, which in fact nurses were. Bedside nursing as known in modern countries was practically non-existent.

2. The Council of Nursing Education was formed in March 1946 and its recommendations were the basis of a reorganized nursing education system in Japan. In July 1948 the Public Health Nurse, Midwife and Nurse Law No. 203 was promulgated, setting up new standards of education, registration and licensure of nurses, public health nurses and midwives.

3. A model nursing school was established in June 1946 enrolling high school graduates for a 3-year course in nursing. In 1948 two more model nursing schools were opened.

4. In April 1947 a four-month refresher course for public health nurses was opened at the Institute of Public Health for the purpose of training nurses employed in health centers and prefectural and municipal departments of health. To date 448 nurses representing all prefectures of Japan have been trained in this course. In November 1947 the Japanese Anti-Tuberculosis Association began a course in tuberculosis nursing for public health nurses, 134 nurses having received training under this program in courses varying from 4 to 6 months in duration.

5. Refresher courses, re-education programs and institutes for nurses, public health nurses were initiated in 1946 and have been held on national, regional and prefectural levels with over 10,000 nurses having received training under these programs.

6. In 1946 the Japanese Midwives, Clinical Nurses and Public Health Nurses Association was organized free from government control. This organization has contributed much to the educational advancement of the nursing and midwifery programs in Japan. Through this organization Japan was re-admitted into the International Council of Nurses in June 1949. Since July 1949 it has published its own official professional organ "Nursing".

7. In July 1948 a Nursing Section was established in the Ministry of Welfare under the Medical Affairs Bureau, giving nurses the opportunity to manage the affairs of nurses, public health nurses and midwives. Since 1948 forty-four prefectures have established nursing section or divisions within their health departments.

#### VI. VETERINARY AFFAIRS

1. Veterinary education has been reorganized, and the national licensing of all veterinarians is now required. The establishment of effective animal disease control programs has been of material value in the increase of the goat and dairy cattle populations, resulting in increased quantities of milk for infants, convalescents, pre-school children and school children.

2. The enforcement of the Food Sanitation Act is directly responsible for the reduction of inherent health hazards to a minimum, thereby improving the quality of all foods and beverages offered for consumption.

#### VII. WELFARE

1. Relief work in Japan prior to the Occupation was carried out by various voluntary and government organizations and was in no way constituted to meet the emergency problems of food, clothing and shelter of the millions of destitute persons found in the country upon the termination of the war or the 6,000,000 repatriates returned to the country with little more than the belongings they could carry on their backs as their sole possessions. The cities had been evacuated prior to the bombings in many cases and at the beginning of the Occupation thousands of persons were streaming into the cities, living in the rubble and railway stations, without homes and without work. Factories were closed and their reopening was impossible to determine. It was therefore decided that persons who had been evacuated into the country would not be permitted to return to the burned out cities unless a job

there and a place to live could be provided. Being dispersed throughout the rural areas, they could at least assist in the production of the maximum quantities of food possible, rather than live in refugee camps in idleness in the urban areas.

2. A Daily Life Security Law was passed by the Diet, and administered by approximately 150,000 social workers. This provided assistance to those who through no fault of their own were found to be in need. The peak load at any one time receiving public assistance was approximately 3,100,000 in 1946, which with careful screening and assistance in re-employment have been reduced to 1,595,119 as of December 1949. Returning repatriates who have lost all their belongings are provided loans in order to assist them in establishing themselves either on farms or in useful occupations in the urban areas. Orphans and homeless persons found in the urban areas were provided with food, clothing and medical care and those requiring institutional care were provided with it. Former military barracks and war factory dormitories were utilized in providing housing. This combination of the control of the population and the de-concentration of refugees has operated successfully in preventing suffering and unrest, which invariably accompanies long periods of retention in refugee or concentration camps, although more than 6,000,000 repatriates have been absorbed in this country of 81,000,000 within the last three years. (See Chart No. 4)

a. Foreign Nationals

- (1) At the beginning of the Occupation, foreign nationals numbered 2,000,000 Koreans, 30,000 Formosans and Chinese and 7,500 various other nationalities.
- (2) Of those foreign nationals who were residents in Japan at the time of the surrender, approximately 600,000 Koreans of the original group have elected to remain in Japan and receive the same care and treatment as Japanese citizens. Chinese-Formosans and other foreign national groups have been given opportunities for repatriation, however, very few persons in these categories have elected to be repatriated.

b. Housing

- (1) Prior to World War II it was estimated that Japan had 14,000,000 homes which included structures of all types of construction, from modern cement and wood buildings to the typical style Japanese wood and straw buildings. At the end of hostilities some 4,500,000 homes had been destroyed through bombings, fires and

natural catastrophies. As the nation had diverted its efforts to war time requirements, no new housing construction had been undertaken; consequently a serious housing deficiency existed.

(2) The Board of Reconstruction was established early in 1946 and was made responsible for the surveying of housing needs and making available essential materials based on these surveys. Under this coordinated program an average of 23,000 homes are being built in Japan each month. From August 1945 to December 1949 a total of 1,586,632 dwelling units have been constructed in Japan, with a total of 28,861 units being built in December 1949. The lack of materials as well as funds has not permitted a wide expansion of this building program without endangering the Japanese economy. Progress, however, has been steady even though natural catastrophies, such as the earthquake and flood in Okayama prefecture and Shikoku region areas in 1946, the Kanto region flood in September 1947, and the Fukui earthquake disaster in July 1948, resulted in further housing shortages.

c. Licensed Agencies for Relief in Asia (LARA)

(1) Early recognition by SCAP of the need for a channel through which to funnel all donated relief supplies coming to Japan from the United States and other countries resulted in an agreement with interested organizations and the inauguration of LARA. Under the SCAP-LARA agreement the Japanese Government assumed all costs from dock to distribution under the general supervision of SCAP. LARA was authorized to ship up to 2,000 tons per month. Their primary plan of operation is to raise the caloric intake of persons in institutions, orphanages, hospitals, and sanatoria by supplementing the food received in the official Japanese rations.

(2) The first shipment of LARA relief goods arrived in Japan 30 November 1946, consisting of 350 tons of food and clothing. As of December 1949, a total of 233 shipments amounting to approximately 10,456 tons valued at \$6,500,000 has been received and distributed in Japan to the benefit of 7,000,000 needy people. In addition to these relief supplies the LARA organization has shipped 2,190 goats to Japan, a gift of the Heifers for Relief Committee of the

Brethren Society. The relief afforded to the Japanese through LARA shipments has been of material assistance.

d. The Japanese Red Cross

- (1) The Japanese Red Cross was regarded as the second greatest Red Cross Society in the world. Its organization was not dissimilar to that of the American Red Cross but in function it followed the European pattern with special emphasis placed on a nationwide system of hospitals, clinics, sanatoria and schools of nursing. Prior to World War II the society, by Imperial Ordinance, was placed under the control of the Sanitary Commission of both the Army and Navy. The wartime Red Cross program, therefore, was geared to the war effort and its pre-war activities were measurably altered to meet military demands.
- (2) On 20 September 1945, the American Red Cross was invited to assist SCAP in reorganizing the Japanese Red Cross society along democratic lines with primary emphasis on serving the civilian health and welfare needs of the Japanese people.

e. Child Welfare

- (1) Child Welfare as defined in a modern welfare program was practically unknown to the Japanese prior to the Occupation.
- (2) A Child Welfare Law has been passed and the necessary organization established at all echelons of the Government to provide for special needs of children.

f. The School Lunch Program

- (1) A small school lunch program had been inaugurated by the Japanese prior to the beginning of the war. However, it had completely collapsed during the hostilities.
- (2) A school lunch program was inaugurated by SCAP in December 1946, in view of the fact that nutrition surveys had indicated that Japanese school children were being retarded in growth and showed other evidences of malnutrition. The school lunch program originally was able to provide from two to five mid-day lunches per week for some 251,000 school children.

Food supplies were obtained through releases of former Japanese Army and Navy supplies and from other indigenous sources. LARA also contributed to this program, supplying a good share of the powdered milk requirement. The program at present provides supplementary feedings for approximately 7,104,881 children, out of 18,000,000 who need such supplementary feedings. In those children who have been receiving this supplementary feeding, deterioration in the growth rate has been checked and normal growth rates have been re-established.

(3) The limiting factor in the needed expansion of this program is the availability for importation of the necessary quantities of powdered skim milk and other proteins in which the Japanese children's diet is so deficient.

g. Disaster Relief

(1) Japan is a country of major disasters. Earthquakes, floods, typhoons and fires which wipe out whole cities occur all too frequently. So far, at least two such major disasters have occurred during each of the four years of the Occupation. The Japanese had relied upon the Japanese Army and the national government police as the agencies in disaster relief work prior to the Occupation, but since neither of the organizations now exist it was necessary to establish a civilian disaster relief organization.

(2) As a result of the December 1946 earthquake a proposed national disaster plan was drawn up. After several months of study, to determine the best means of implementing this plan, it was finally submitted to the Diet and became Public Law No. 118 on 18 October 1947. The National Disaster Law provides for monetary responsibility by both national and prefec-tural governments. The law provides for a National Disaster Board. This Board is responsible for formulating plans of operations and direction in the event of disaster; also to expedite the flow of disaster supplies. The law further provides for Prefec-tural Disaster Boards. Each prefecture is required to have disaster operating teams composed of police, health officials, welfare officials, economic officials, firemen and engineers. The Japanese Red Cross is recognized as a quasi-governmental agency in times

of disaster and is responsible for the coordination of all voluntary groups or agencies. During the Fukui earthquake, the implementation of national and prefectural disaster plans was prompt and efficient and was the cause of favorable comment from many sources. Disaster teams from the surrounding prefectures furnished aid to the stricken area immediately following notification of the earthquake and with the Japanese Red Cross coordinating the volunteer agencies, problems of food, clothing, medical supplies and medical treatment were handled efficiently.

(3) The development of a comprehensive national tidal wave warning system in December 1949 has further strengthened the national disaster preparedness plan. It permits dissemination of disaster warnings through national, prefectural and local communication channels.

h. Cooperative Agency for Relief in Europe and the Far East (CARE). On 21 August 1947, SCAP authorized CARE to extend their operations to Japan. Since the beginning of the CARE program in Japan from 1948 to December 1949, a total of 74,176 packages have been received. At present there are six types of packages available for distribution in Japan: food, woolen suiting, knitting wool, blankets, cottons and holiday foods.

i. Social Work Education and Training. The developments in public and child welfare which emphasized the importance of using paid welfare workers rather than volunteers increased the already existing need for qualified social workers. The two schools of social work (in Tokyo and Osaka) have increased their enrollments and improved their curriculum to include field work practice and have conducted special three-month courses to meet the needs of personnel already employed in specialized fields such as medical social work and child welfare. An in-service training committee in the Ministry of Welfare conducted an institute for in-service training directors from each prefecture. Prefectures have established scholarships for social work training. Seventeen applications for United Nations Fellowships were forwarded and several students have obtained scholarships through other sources for social work education.

j. Community Chest

(1) The constitutional prohibition against governmental subsidization of private welfare agencies and operations, together with the break-up of the "Zaibatsu" and the loss of this source of private donations to

private welfare activities, forced the private agencies to appeal for help and counsel in planning programs for private agency fund raising. A national committee, similar in purpose to the Community Chest in America, was organized to develop broad plans and programs of fund raising at prefectural level.

- (2) The organization of a National Fund Raising Committee for the financing of recognized private welfare agencies was established during the summer of 1947. Fund drives which occurred in the winter of 1947 were preceded by a nationwide appeal through the press, radio and other media in which an effort was made to secure the participation of every adult in Japan. The national goal was set at ¥ 678,200,000 with each participating prefecture having a quota to attain. Due to the seriousness of the Kanto regional flood in September 1947, four prefectures which suffered heavy damages did not participate. The remaining 42 prefectures, however, raised a total of ¥ 571,071,681, or 84.2% of the national goal. This was a very commendable effort for the first such campaign ever conducted in the nation.
- (3) The successive fund campaigns in 1948 and 1949 have further demonstrated the acceptance by the Japanese of the principle of central financing of private welfare enterprises. The 1948 campaign goal was ¥ 1,175,000,450 of which 85.5% was realized. In 1949 the goal was set at ¥ 1,221,717,000 of which by 31 December 1949, 95% had been subscribed with returns still coming in at a rate which indicated the goal would be topped.

k. UNICEF and United Nations

- (1) The UNICEF program has been of great value to the Japanese people and the Occupation. The program, started in 1949 at the request of SCAP, consists of a school lunch demonstration program which involved 51,771 children, the day nursery program including 3,868 children, the infant feeding program including 2,300 infants, and a clothing program in which UNICEF provided raw cotton which was manufactured into childrens clothing outfits. Cost of manufacture and distribution was borne by the Japanese Government and 248,710 children received complete outfits. The continuation of the UNICEF program in Japan has been

assured by additional allocations and it is not anticipated it will be concluded until 1951.

(2) In addition, the services of a highly qualified specialist in child welfare has been made available to the Public Health and Welfare Section and the Children's Bureau of the Welfare Ministry by the United Nations, Division of Social Activities, Department of Social Affairs, for study of the services offered by the new Child Welfare Centers in Japan. A plan has also been developed for participation by selected Japanese social workers in the United Nations Fellowship program and the first students are expected to leave for foreign study visits during 1950-51.

1. Physically Handicapped. Legislation passed in 1949 provides for a national system of rehabilitation for Japan's 800,000 physically handicapped including the development of model rehabilitation centers responsible for offering services to preserve, restore and develop the ability of the disabled persons to engage in gainful employment and a useful place in society.

## VIII. SOCIAL SECURITY

1. Since 1871 the Japanese have been developing social insurance programs, beginning with protection to government officials and gradually extending their application to industrial workers and the rural population. At the beginning of 1945, under the compulsory membership provisions of all insurance laws then in force, coverage of the rural population under National Health Insurance had, in approximately 10,900 rural communities, reached a level of 41 million, while under other programs applicable to industrial and commercial workers and to government employees, coverage had risen to 27 million. Thus, at a wartime peak, 68 million or 85 percent of the population had some form of social insurance protection. This pattern was seriously disrupted at the close of the war and in 1946 more than 60 percent of the coverage in rural communities had ceased or become meaningless because of financial difficulties.

2. The Japanese social insurance programs other than those applicable solely to government workers, are (See Chart No. 5):

a. Health Insurance (1922). A compulsory system for employees of industrial and commercial concerns employing five or more and with contributions divided equally between employer and employee. Prior to the enactment of the Workmen's Accident Compensation Insurance Law in 1947, this program provided for both occupational and non-occupational illnesses and accidents but now is limited to non-occupational disabilities. Cash benefits are paid to replace wage loss during brief

illnesses, and medical care, maternity care and funeral expenses are provided. In 1949, 6.1 million workers plus 14.0 million dependents were covered. Although enacted in 1923, this law was not put into operation until 1927 because of conditions following the 1923 earthquake.

b. Welfare Pension Insurance (1941). This is a system covering practically the same employees as are covered by Health Insurance (the difference in number covered being accounted for mainly by municipal employees who participate in Health Insurance but whose retirement programs are provided by municipal ordinance), with contributions divided equally between employer and employee. Following the enactment of the Workmen's Accident Compensation Insurance Law, amendments to the Welfare Pension Insurance Law removed distinctions between occupational and non-occupational benefits. No benefits are paid under the Welfare Pension Insurance Law, however, for occupational disabilities covered by Workmen's Accident Compensation Insurance during the six-year period compensation is paid under the WACI Law. Cash benefits are paid for continuing invalidity, survivors and retirement. Old age pensions will be payable beginning in 1956. In 1949, 5.9 million workers were covered.

c. Workmen's Accident Compensation Insurance (1947). This program supplanted the Employers' Liability Insurance Law of 1931 which provided for employer-supported reserve funds from which the employer was reimbursed for medical care and cash benefits for sickness and continuing invalidity (lump sums), funeral and survivors. Coverage extends generally to concerns employing five or more persons but in certain hazardous occupations includes undertakings employing only one worker. Medical care is provided and cash benefits are paid to replace wage loss during brief illnesses, for continuing invalidity, funeral and survivors -- all related to occupational disabilities. In 1949, 6.7 million workers were covered. Government workers and seamen are excluded.

d. Unemployment Insurance (1947). This was the only type of social insurance not provided by Japanese law at the time of the surrender ("retirement allowances", paid as lump sums -- not weekly benefits -- on leaving employment, wiped out the worker's accrued rights to old age and invalidity pensions). Coverage applies to establishments employing five or more persons (including day laborers as of January 1950).

e. Seamen's Insurance (1939). A composite social insurance program for seamen serving on fishing vessels of thirty tons or more and other vessels of five tons or more, with contributions divided equally between employer and seamen except for the total cost of occupational disability benefits which are borne by the employer.

Comprehensive benefits pertain to both occupational and non-occupational disabilities and include cash benefits for temporary sickness and continuing invalidity, unemployment (since 1947), retirement, funeral, survivors and old age (payable beginning in 1950 for seasonal fishermen) and medical care. In 1949, 100,000 seamen plus 200,000 dependents were covered.

f. National Health Insurance (1938). This program extends the prepaid health insurance concept to the rural communities by sponsoring voluntarily (through amendment in 1948) organized town and village health plans supported by members contributions and a government subsidy. Administration is under the direct control of the local municipality concerned, either through its own offices or through an association authorized by such municipality. Coverage includes primarily the rural population and in many urban areas, the self-employed. Medical and maternity care and, in some instances, funeral benefits, are provided. In 1949 the program covered 27.9 million persons.

g. The existing social security programs have been the cause of great concern to the Japanese Government and assistance of SCAP was requested. Two missions have been sponsored from the United States: the Social Security Mission and the American Medical Association Mission. Their reports were given to the Japanese Government for use as documents of reference and study in formulating plans to conform to the objective of the Occupation to promote the maintenance of a comprehensive and adequate social security program based on democratic precepts and within the limits of the nation's resources.

h. Pending the issuance and acceptance of such national plans as may be formulated by the Japanese Advisory Council on Social Security and agreed to by the Diet, the compulsory aspects of the National Health Insurance program have been modified to permit local option; unemployment and workmen's compensation insurance protection have been furnished industrial and commercial workers; the democratic institutions of advisory councils, appeals and fair hearing, and comprehensive informational service and operational reporting have been incorporated into the administration of all programs; and the medical profession has been released from government controls and permitted full freedom in conducting their practice and individual choice in participation in the social insurances.

## IX. NUTRITION

1. Historically, Japan has for many years had a food deficiency. With a population now of 81,000,000 and limited areas for production (only 16% arable), Japan has been dependent on food imports amounting to at least 15% of her requirements. The diet is basically composed of rice, fish and fresh seasonal vegetables. The war did not create

problems in nutrition but only emphasized the inadequacy of the indigenous food supply, consequently the curtailment of imports and the shortages of the necessary nutrients are directly related to the health of the civilian population. During the war with China and later World War II, the Japanese people were on a restricted ration which became more severe as the war progressed and imports were curtailed. Surveys indicated that the children of cities had been underfed, resulting in lowered height and weight compared with the years previous to 1941.

2. An accurate appraisal of the Japanese food situation was dependent upon data concerning the nutritional status of the population and information as to the actual food consumption. As the official ration level was below the minimum subsistence level, it was anticipated the consumers would supplement ration issues by home production, gifts and purchases of non-rationed food. Nutrition surveys were conducted in Tokyo starting December 1945. These initial nutrition surveys were extended to include eight large cities and 27 prefectures. They are conducted every three months (February, May, August and November). The surveys also include physical examinations for certain symptoms associated with nutritional deficiency, including body weights and heights. In addition, the food consumption is obtained on one-half of the people given physical examinations. The total number of individuals examined every three months has averaged about 150,000. This represents approximately 1% of the population in these designated areas who are representative of all age groups and all economic groups. The results of these surveys have been utilized as a basis for recommendations for essential food imports. Had these minimum food imports not been received, mass starvation involving several millions of people would have resulted.

3. Nutrition surveys have been extended and now include twelve large cities, all other cities over 30,000 population, and the entire forty-six rural prefectures. Scientifically conducted by improved statistical sampling, these nutrition studies have been proven to be a satisfactory method of comparing food consumption and nutrient intake with the nutritional status "before and after". They also are a means of ascertaining the percentage of the population that is adequately fed as well as determining the distribution of food supplies in the country as a whole.

4. During the past year, PH&W Section has assisted in initiating similar type nutrition surveys in Okinawa.

## X. SUPPLY

1. Supply Situation at Time of Surrender. a. During the war the medical and allied industries suffered heavy losses. Approximately 50% of the factories engaged in the manufacture of medical supplies and equipment had been destroyed or converted to production of war

materials. Due to the lack of raw materials and the deterioration of equipment, the remaining factories, when the Occupation started, were producing only 20% of pre-war requirements. The government had assumed rigid control over all medical supply and equipment production, purchasing the bulk of the products for the armed forces. This resulted in the civil population receiving a very small share of these critical items. No medical supplies had been distributed to civilians by the Japanese Government since June 1945. Production and distribution was exercised through a series of control associations and companies, each of which handled a specified commodity group. Control associations purchased the entire production of manufacturers and conducted a wholesale operation through sales to corresponding control companies in each prefecture.

b. Immediately upon surrendering, all supplies and equipment of the Japanese Army and Navy were confiscated by the Occupation Forces. Upon the completion of an inventory, non-war materials, including medical supplies, were returned to the Japanese Government for civilian use. These represented a sizeable stock. Steps were taken to require distribution of these supplies to physicians, dentists, veterinarians, pharmacists, sanitarians and hospitals.

2. Production. In planning to provide adequate medical supplies and equipment to meet the needs of the civil population, the problem of utmost importance that confronted SCAP was (1) should all needed supplies be imported at the expense of the American taxpayer, or (2) should every effort be made to increase and stimulate indigenous Japanese production, and import only those materials, preferably in raw form, which would not be available in Japanese supply. It was decided that the latter course would be followed and immediate steps were taken to rehabilitate the Japanese medical supply and equipment industry. Japanese Pharmaceutical circles had been cut off from technological developments in other world areas during the war years. Efforts were made to introduce modern drugs by supplying technical information and guidance. Certain biological products, new sulfa drugs, DDT, penicillin, hexylresorcinol, and more recently streptomycin, were introduced and, except for streptomycin, are being manufactured in sufficient quantities to satisfy all requirements. Emphasis now is on production for export.

3. Distribution. The present distribution system of medical, dental, veterinary, and sanitary supplies and equipment is working satisfactorily. The current system is not unlike that in the United States, where the normal flow of supplies is from the manufacturer to the wholesaler, thence to the dealer and consumer. Freed from all government control except that necessary for rationing of critical items still in short supply, the present method has permitted the practicing doctor, dentist, veterinarian, and sanitarian to obtain the medicines and equipment he requires with a minimum of delay.

4. Pharmaceutical Affairs Law. To satisfy a recognized need for drastic reform in pharmaceutical affairs, a new law passed by the Diet became effective 29 July 1948. This Pharmaceutical Affairs Law controls all activities related to the manufacture, preparation, sale or other distribution of drugs, devices, and cosmetics. It created a National Board of Pharmacy with members appointed from among leaders in the fields of medicine, pharmacy, and education. It provides that all drugs, devices, and cosmetics meet the requirements and conform to the standards established by the Ministry of Welfare, pursuant to recommendations of the National Board of Pharmacy. The law governs licensure of pharmacists and pharmacies, and of manufacturers, importers, and sellers of items under its jurisdiction. It provides that pharmacists, in order to qualify for license, must have been graduated from an accredited college or university, and, for the first time in Japan, must have passed the National Pharmacists Licensure Examination conducted by the National Board of Pharmacy. The sale of poisons and powerful drugs is strictly controlled. The sale or other distribution of sulfanilimide and its derivatives, penicillin, and streptomycin is prohibited except pursuant to the prescription or under the direction of a licensed physician, dentist, or veterinary surgeon. Heavy penalties are provided for violations of the provisions of the law.

5. The Japanese Pharmaceutical Association. The Japanese Pharmaceutical Association, formerly under strict government influence, has now been reorganized under democratic principles. The first regular election of officers was accomplished in August 1948. Membership is limited to licensed pharmacists; associate membership is offered to others in the field of pharmacy. Pharmacists have evidenced considerable enthusiasm in improving their standards, and the current availability of all types of drugs has stimulated their interest in forming an association that will receive proper professional recognition.

6. Pharmaceutical Education. To raise the professional status of pharmacists, reforms in the educational structure were required. A Pharmaceutical Education Council was formed to make recommendations and assist in establishing school standards and curricula. This Council has been absorbed into the Education Committee of the Japan Pharmaceutical Association. The former three-year technical school level of schools of pharmacy has been raised to a four-year course of university level which will become fully operative in 1951.

## XI. NARCOTICS

1. No control over narcotics existed in Japan at any time prior to the surrender. Emphasis was placed on production of narcotics, from opium and coco leaves imported from Manchuria, Mongolia, Formosa, Iwo Jima, Okinawa and the Middle East, with complete disregard of international obligations to limit and report such transactions to international bodies charged with regulating the supply and distribution of

narcotics throughout the world. Figures of production, as furnished by the manufacturers to the Japanese Government, were maintained in Japanese Government files but "planned" figures showing, for instance, one-sixth of the actual production of heroin, were submitted to the Supervisory Body of the League of Nations as true figures. Heroin was shipped from Japan and Korea to Manchuria in quantities that would more than suffice for total world requirements. At the beginning of the Occupation, narcotics, both finished and crude, were scattered throughout Japan in caves, medical depots, Army and Navy hospitals and other military and industrial establishments. Any doctor or pharmacist in Japan could purchase and dispose of any amount of narcotics.

2. After determining the laxity of controls that existed over narcotics in Japan, the planting, growth and cultivation of narcotic seeds and plants and the manufacture and exportation of narcotics were prohibited; laws establishing strict centralized control over narcotics were enacted; a narcotic enforcement agency extending throughout every prefecture in Japan was organized; all heroin, a high-tension, dangerous narcotic formerly reaching illegal markets in the United States, was destroyed. Importation of narcotics was limited to the amounts deemed necessary for medical treatment of the Japanese people. In the fall of 1945 after the growth, manufacture and exportation were prohibited, all crude and semi-processed narcotics were taken into custody by the Occupation Forces. All former Japanese Army and Navy medical narcotics were likewise taken into custody, inventoried and stored. These medicinal narcotics have since been turned over to SCAP approved wholesale houses for repackaging and distribution under strict control regulations. Legislation establishing a strong centralized control over the distribution of narcotics was enacted. Manufacture, as an interim measure, to supply the medical needs of the Japanese people was authorized.

3. Constant supervision and training of narcotic agents, and improved liaison with the police and other law enforcement agencies has resulted in large amounts of narcotics being intercepted either before reaching Japan or upon arrival from the Asiatic Continent. The total number of persons arrested for narcotic violations in 1949 was 1999. Four hundred sixty-two of these were foreign nationals, some of whom were sentenced to deportation following terms of penal servitude.

4. Special procurators have been designated in each district and appeal court to prosecute narcotic violators. These procurators have been given special indoctrination concerning the seriousness of narcotic violations in order to obtain more severe sentences for narcotic violators.

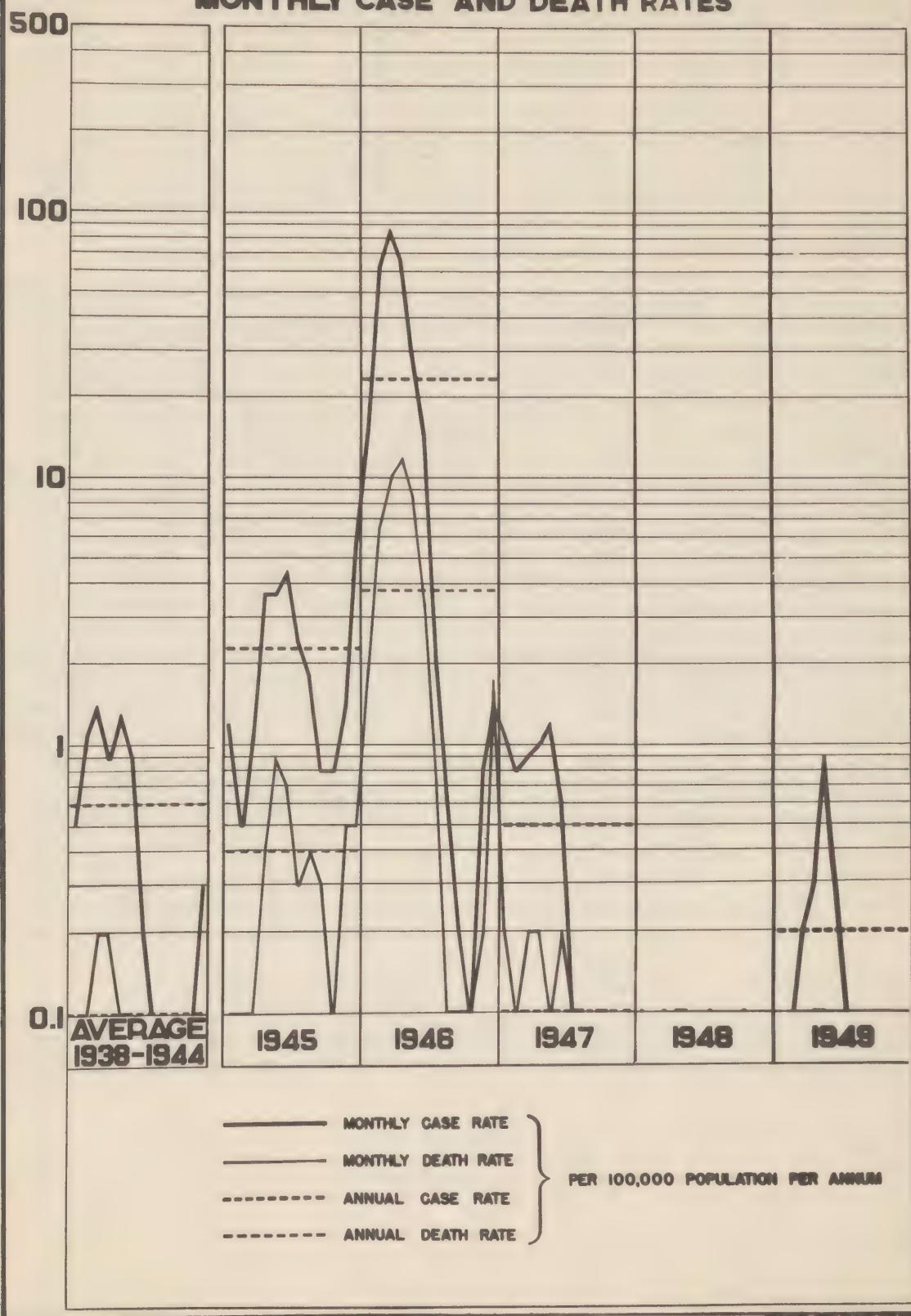
## XII. CONCLUSIONS

1. In preventing widespread disease and unrest in Japan, the four fundamental aspects of the problem have of necessity been integrated. The Preventive Medicine aspects of the problem cannot succeed unless adequate medical care is provided for cases of diseases uncovered in the preventive program. Medical care facilities, no matter how good they may be, are limited in their value if they cannot be used and are therefore dependent upon the Welfare program, particularly for the medically indigent. The Social Security program must be integrated with the Welfare program and the Medical Care and Disease Prevention programs, as one method of financing part of the work through the insurance principle.

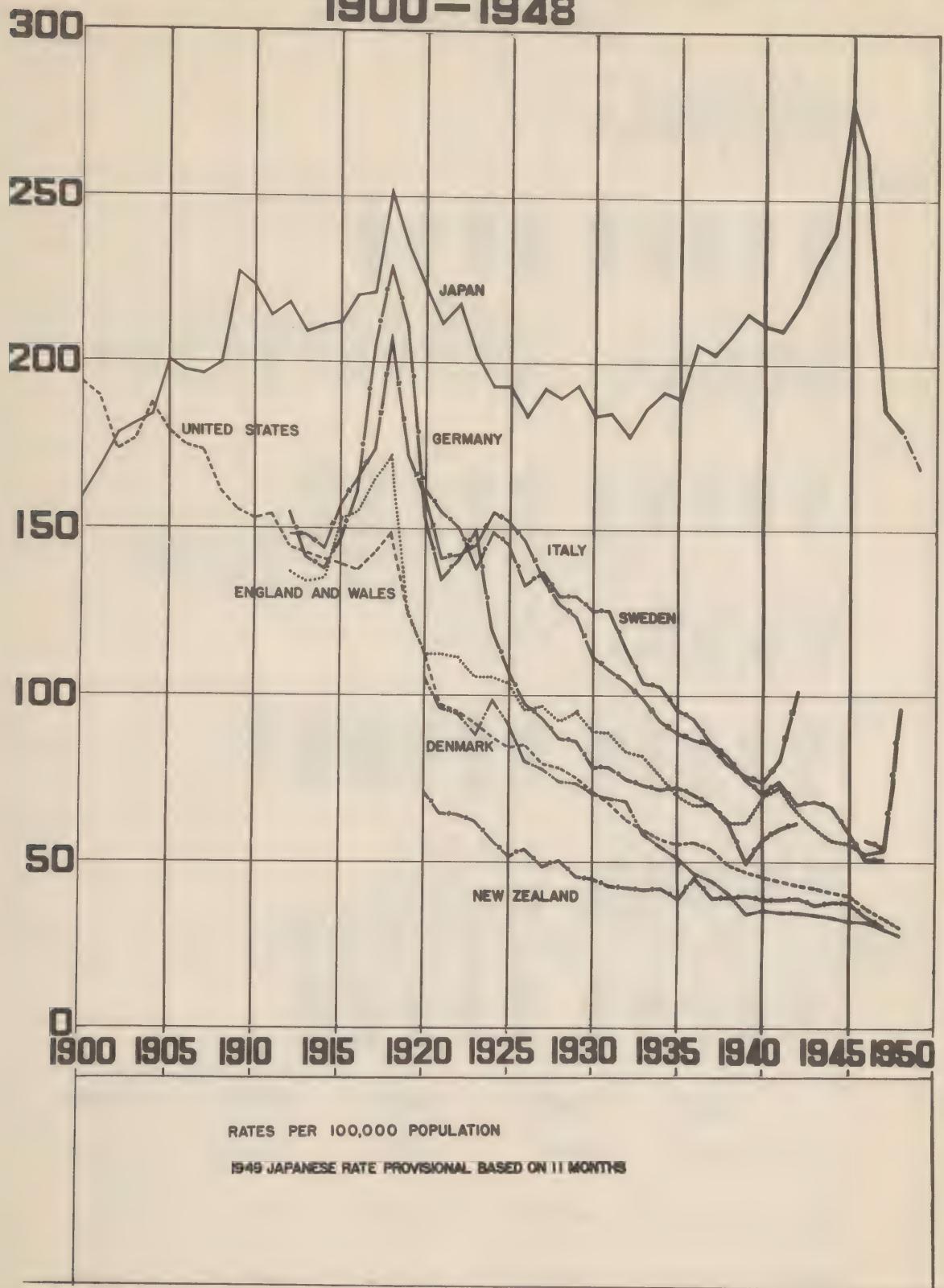
2. Disease is seldom eradicated. It is only controlled. Progress has been made in controlling disease in Japan through the integration of the four basic aspects, but outbreaks of any of the diseases under control can be anticipated if the slightest relaxation of any part of the health and welfare program is permitted. An organizational framework or blueprint has been established in these fields; however, the largest part of the problem is still ahead. That problem is one of advice, guidance and training. It involves, in some of the professions, bridging a gap of twenty to thirty years in professional knowledge. Until such time as an adequate number of Japanese can be well trained in modern knowledge in the fields of health and welfare, so that the Japanese health and welfare program may stand on its own feet, there is danger of relaxation of control, with a resulting widespread outbreak of disease, followed by the inevitable fear and unrest which accompany such outbreaks. The task of training competent doctors, nurses, sanitarians, social workers, nutritionists and others in the various professions which implement a health and welfare program for a nation of 81,000,000 people is a tremendous one and will take time. Progress is being made in this field. The benefit from this training program will not be realized for some years to come, as such far reaching changes cannot be effected within the space of a few short years.

# SMALL POX: JAPAN

## MONTHLY CASE AND DEATH RATES

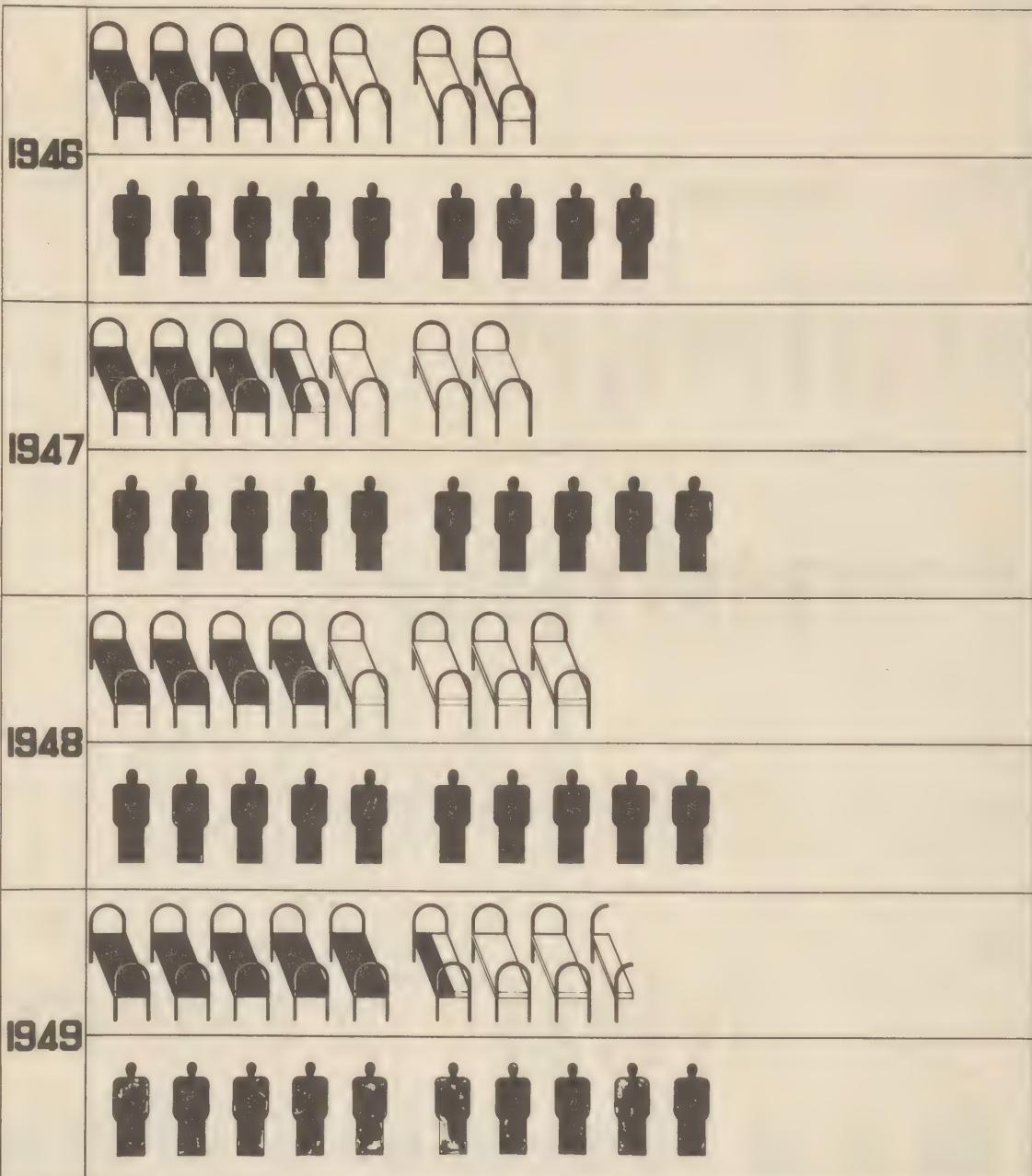


# TUBERCULOSIS DEATH RATES 1900—1948



# HOSPITAL PATIENTS

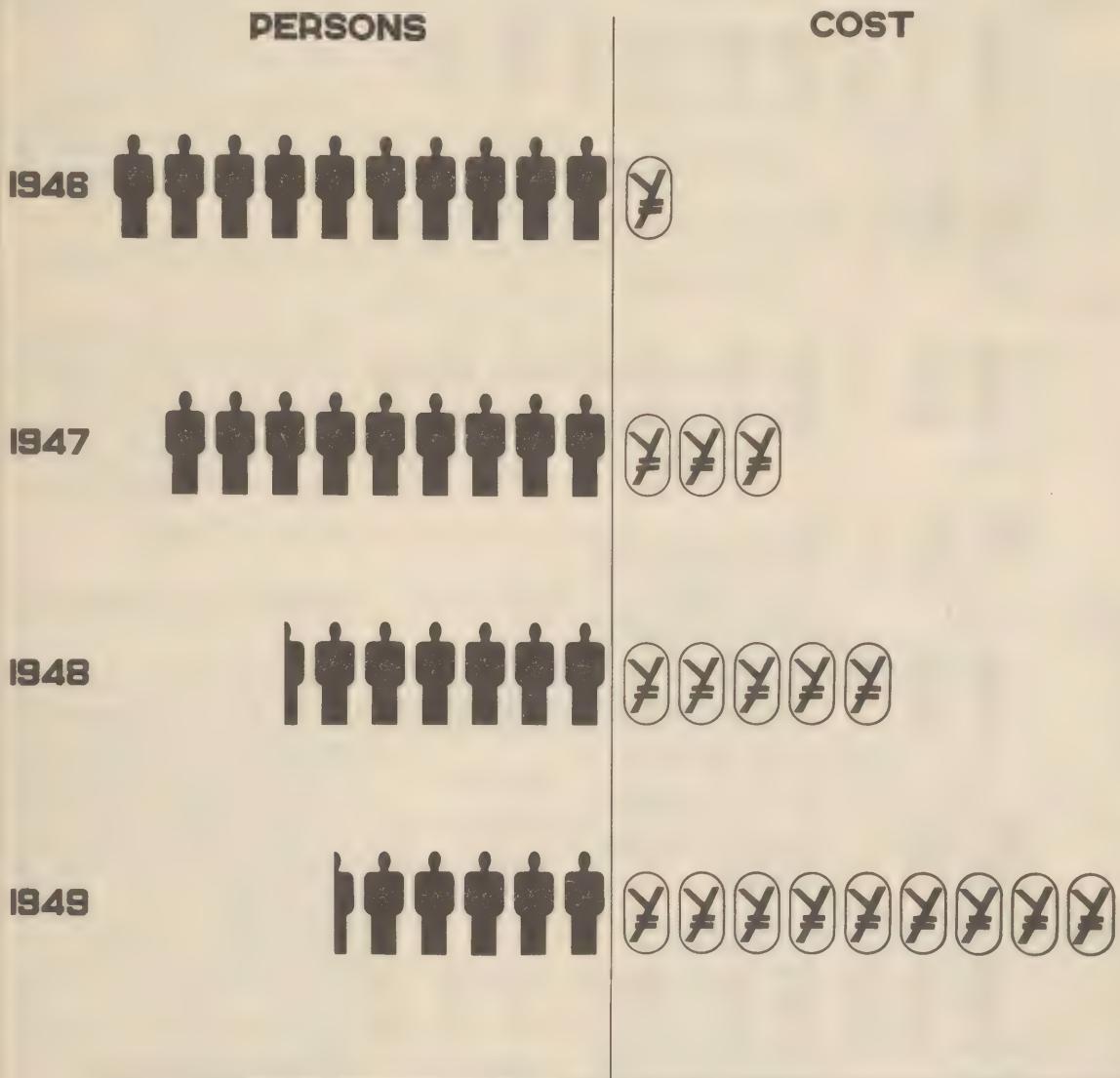
JAPAN, 1946-1949



EACH FIGURE REPRESENTS 30,000 UNITS

# PUBLIC ASSISTANCE

## JAPAN: 1946-1949



ALL DATA ARE FOR MONTH OF AUGUST OF THE YEAR INDICATED

EACH FIGURE

1946

1947

1948

1949



300,000 PERSONS

2953,298

2,688,891

1,903,539

1,681,166



100,000,000 YEN

101,785,455

315,567,188

479,065,048

891,879,399

# SOCIAL INSURANCES

LAW	COVERAGE <sup>A</sup>	FINANCED	BENEFITS
HEALTH INSURANCE (1922)	6.1 INDUST. WORKERS & 14.0 DEPEND.	EMPLOYER-EMPLOYEE (50-50) <sup>B</sup>	MEDICAL <sup>C</sup> , SUBSISTENCE <sup>D</sup> , FUNERAL
WELFARE PENSION INSURANCE (1941)	5.9 INDUST. WORKERS	EMPLOYER-EMPLOYEE (50-50) <sup>B</sup>	INVALIDITY, RETIREMENT, OLD AGE, SURVIVORS
WORKMEN'S ACCIDENT COMPENSATION INS. (1947)	6.7 INDUST. WORKERS	EMPLOYER	MEDICAL <sup>C</sup> , SUBSISTENCE <sup>D</sup> , INVALIDITY, FUNERAL, SURVIVORS
UNEMPLOYMENT INSURANCE (1947)	5.6 INDUST. WORKERS	EMPLOYER-EMPLOYEE GOV'T 1/3 EA.	UNEMPLOYMENT
SEAMEN'S INSURANCE (1939)	0.1 SEAMEN & 0.2 DEPENDENTS	EMPLOYER-SEAMAN 68-32 <sup>B</sup>	MEDICAL <sup>C</sup> , SUBSISTENCE <sup>D</sup> , INVALIDITY, RETIREMENT, OLD AGE, UNEMPLOYMENT, FUNERAL, SURVIVORS
NATIONAL HEALTH INSURANCE (1938)	27.9 RURAL & SELF-EMPL. & DEPENDENTS	INSURED <sup>B</sup>	MEDICAL, FUNERAL
GOV'T PENSION SYSTEM (1871)	0.5 GOV'T OFFICIALS	GOV'T 95% -EMPLOYEE	INVALIDITY, RETIREMENT, OLD AGE, SURVIVORS
NAT'L PUBLIC SERVICE MUTUAL AID ASSOCIATIONS (1905) <sup>E</sup>	2.4 GOV'T OFF'L'S & EMPL & 4.2 DEPENDENTS	GOV'T - EMPLOYEE (50-50) <sup>B</sup>	MEDICAL <sup>C</sup> , SUBSISTENCE <sup>D</sup> , FUNERAL, CALAMITY, INVALIDITY, RETIREMENT, OLD AGE, SURVIVORS <sup>F</sup>
LABOR STANDARDS LAW (PUB. EMPL. ACCIDENT COMP) (1947) <sup>G</sup>	2.7 PUBLIC OFFICIALS & EMPLOYEES	GOV'T	MEDICAL <sup>C</sup> , SUBSISTENCE <sup>D</sup> , INVALIDITY, FUNERAL, SURVIVORS
SEPARATION ALLOWANCES (1947)	2.7 PUB.OFF'L'S & EMPLOYEES	GOV'T	UNEMPLOYMENT, SURVIVORS

A NUMBERS IN MILLIONS

B PLUS GOVERNMENT SUBSIDY

C INCLUDES CASH PAYMENT FOR MEDICAL AND RELATED SERVICES

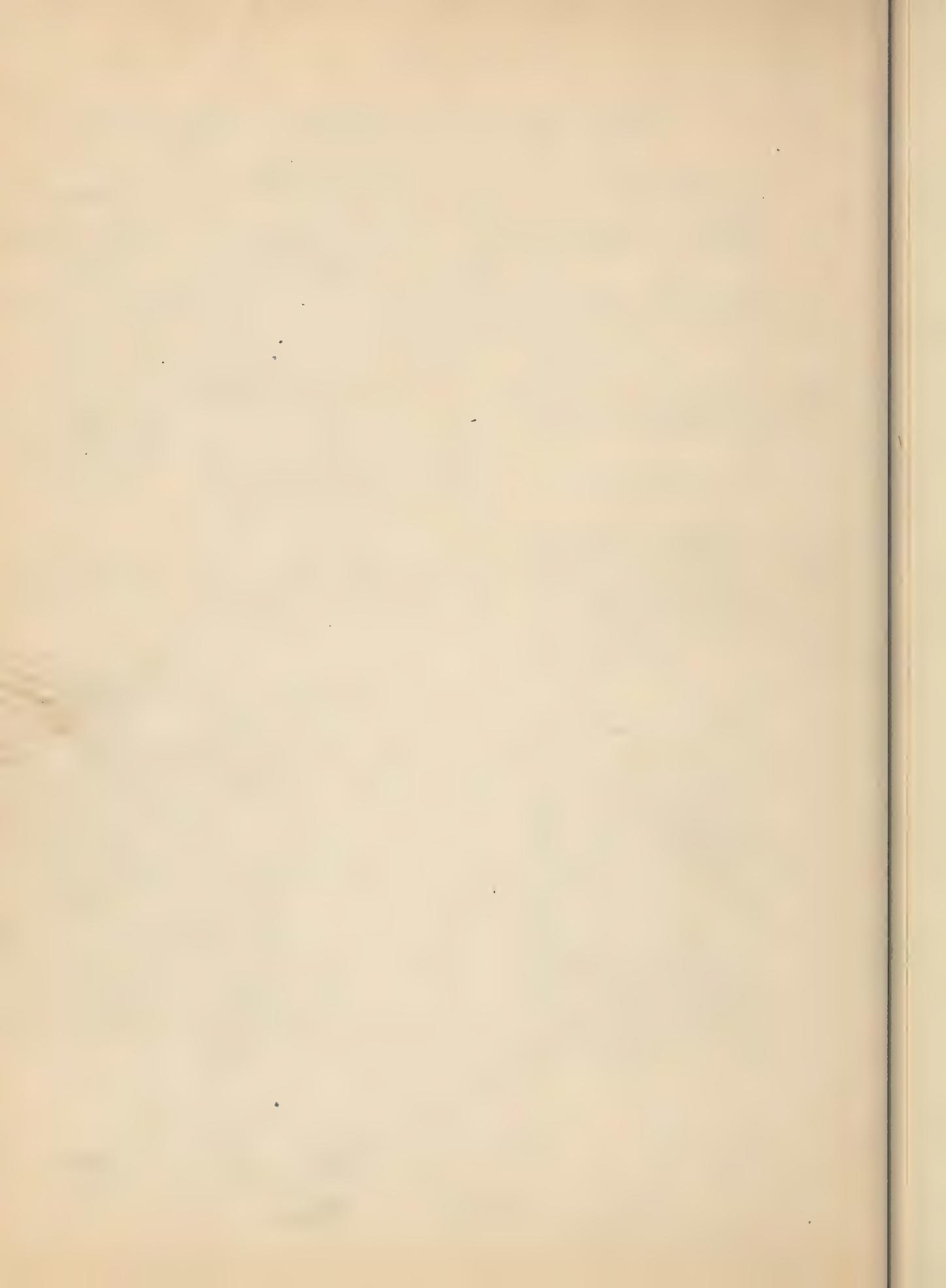
D TEMPORARY CASH WAGE REPLACEMENT DURING ILLNESS

E ORDINANCES CONSOLIDATED IN LAW IN 1948

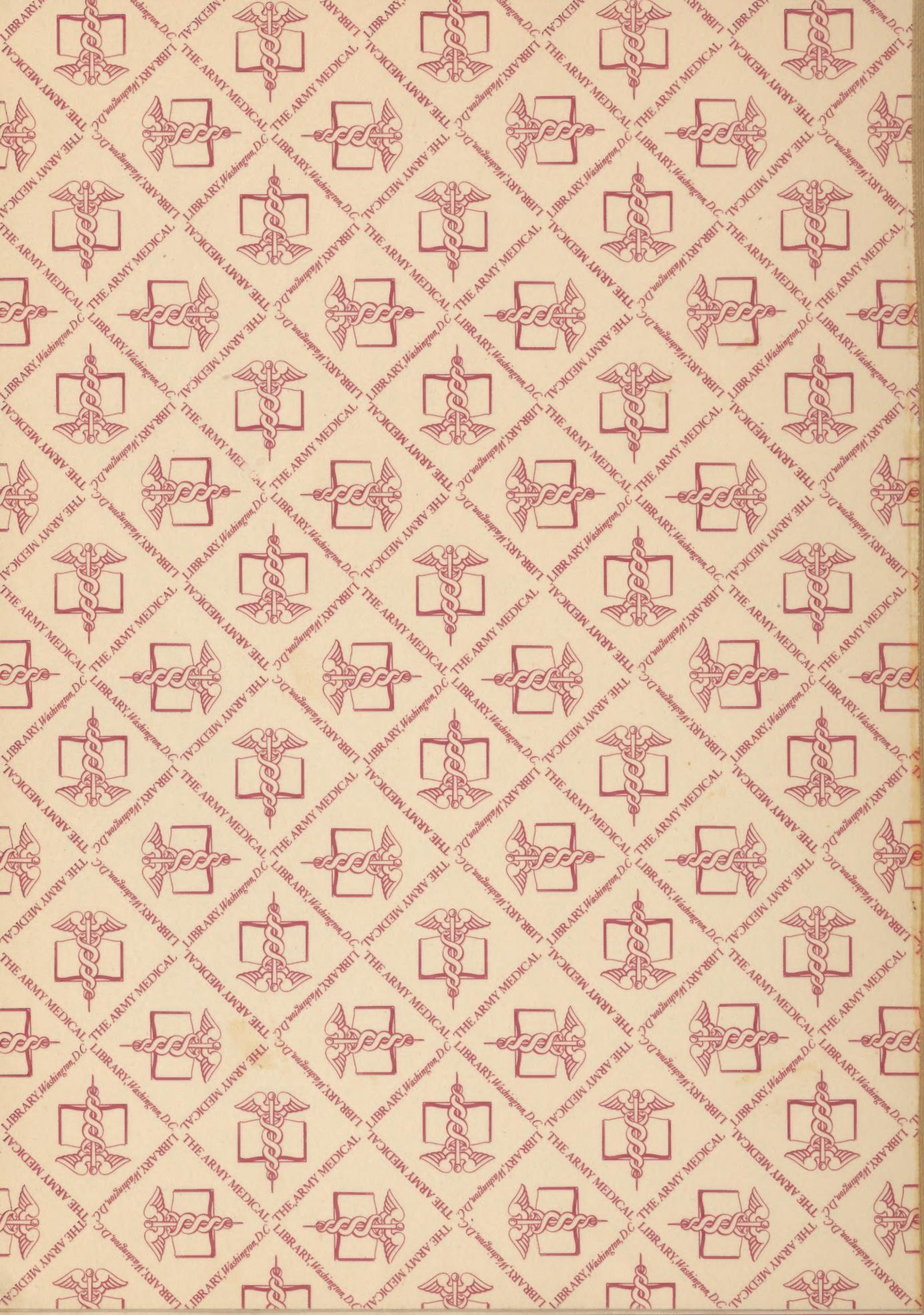
F EMPLOYEES EXCLUSIVE OF OFFICIALS, COVERED BY GOVERNMENT PENSION SYSTEM

G INTERIM STATUS PENDING ENACTMENT OF LAW TO SUCCEED 1892 ORDINANCE









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